MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor UTMB @ Galveston P.O. Box 4786-730 Houston, TX 77210-4786	MDR Tracking No.: M4-04-0492-01 TWCC No.: Injured Employee's Name:
Respondent Texas Mutual Insurance Co. Rep. Box # 54	Date of Injury: Employer's Name: T&L Lease Service Inc. Insurance Carrier's No.: 99D-33101101

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
1-13-03	**2-28-03**	**Inpatient Hospitalization**	**$420,382.19**	**$82,056.34**

PART III: REQUESTOR'S POSITION SUMMARY

Pt. sustained 85% TBSA burns which ultimately resulted in death. UTMB believes the payment received by carrier is insufficient to cover the costs incurred for an injury of this magnitude. Please note – Carrier original payment of $451,431.03 ck# 08826206 was canceled & new pmt was issued. This is not consistent with payment on other cases the same or similar and Dx and cost.

PART IV: RESPONDENT'S POSITION SUMMARY

The Medicare payment in 2003 to UTMB is lower than TMI's, thus TMI's payment is more than fair and reasonable.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). In this particular admission, the principle diagnosis code was 945.39, 948.42, 941.39, 942.29, 943.23 and 308.3, related to trauma care for 3rd degree burns sustained on 85% of body. Pursuant to Rule 134.401(c)(5), the reimbursement for the entire admission shall be paid at a fair and reasonable rate.

Determining the "fair and reasonable" reimbursement can be difficult. In this case, it appears that neither the requestor nor the respondent have persuasively shown that their position represents the appropriate amount. Therefore, an alternate approach is needed to determine the reimbursement amount.

Based on the data contained in the Commission's medical billing database for dates of service in 2003, trauma admissions were reimbursed, on average, at 51.8% of the total charges (total payments divided by total charges). Applying this same formula to this specific case appears to be a sound method to determine the appropriate fair and reasonable reimbursement.

Accordingly, the health care provider is entitled to a total reimbursement amount of $363,594.99. This was calculated by multiplying the total changes of $701,920.84 multiplied by 51.8%.

Since the carrier has previously paid $281,538.65, the health care provider is entitled to additional reimbursement in the amount of $82,056.34.

Based on the facts of this situation, the parties' positions, and the application of the provisions of Rule 134.401(c), we find that the health

care provider is entitled to a reimbursement amount for these services equal to $82,056.34.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $82,056.34. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Allen McDonald, Director	June 21, 2005
Authorized Signature	Typed Name	Date of Order

Decision by:

	Elizabeth Pickle	June 21, 2005
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____